



Nick Cavey -MDInsurance- <nick.cavey@maryland.gov>

2017 Benchmark Health Plan

1 message

Angela Mezzomo <mezzomoang@aol.com>
To: Nick.Cavey@maryland.gov

Thu, May 14, 2015 at 11:00 PM

Dear Mr. Cavey:

The Maryland Speech-Language-Hearing Association (MSHA) is a professional association comprised of over **700 speech/language pathologists and audiologists**. MSHA advocates for people of all ages who have speech, language, swallowing and/or hearing disabilities. MSHA has carefully reviewed the habilitation benefits of the three largest health plans identified by the Maryland Insurance Administration (MIA) and, in agreement with the American Speech-Language Hearing Association, offers the following comments for consideration.

As you know, the Department of Health and Human Services (HHS) adopted a uniform definition of habilitation that States can use as the floor in determining coverage for habilitation services and devices for individual and small employer health insurance plans beginning in 2016.

Habilitation services and devices – Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Beginning in 2017, qualified health plans will be required to not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. This will ensure that visit limits for habilitative services are not combined with and are separate from rehabilitative services. MSHA supports this policy and further requests that benchmark plans should offer separate visit limits for each of the therapies (e.g., speech therapy, physical therapy, occupational therapy) as they provide distinct services focused on different functional goals. For instance, a benchmark plan that only allows 30 combined visits/member/calendar year for rehabilitative or habilitative services is not adequate coverage. It is not uncommon for an enrollee to require up to 20 visits in a 6 week timeframe for speech therapy alone, depending on the diagnosis and treatment plan.

MSHA has been actively engaged in working to ensure comprehensive coverage of audiology and speech-language pathology services for patients with chronic conditions and/or disabilities and fully support the HHS uniform definition. Adopting a uniform definition minimizes the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Habilitation services and devices are typically appropriate for individuals with many types of neurological and developmental conditions that—in the absence of such services—prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood. In addition, rehabilitative and habilitative devices typically prescribed by audiologists and speech-language pathologists include hearing aids, augmentative and alternative communication devices, such as speech generating devices, which aid in hearing and speech, and other assistive technologies and supplies.

Augmentative and alternative communication (ACC) devices are specialized devices that assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices. Hearing aids and assistive listening devices are medical devices that amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional. Examples of these devices include, but are not limited to, hearing aids, cochlear implants, and osseointegrated/bone-anchored hearing aids.

Before the adoption of the recently finalized federal definition for habilitation services and devices, the state of Maryland passed legislation requiring health plans to provide habilitation services to children with congenital, genetic, or early acquired disorders under the age of 19. Maryland also covers unlimited medically necessary visit limits for habilitation services for children under the age of 19. For members age 19 and above, 30 visits per condition per contract year for each therapy (physical therapy, speech therapy, and occupational therapy). This is in parity with rehabilitation coverage. In addition, hearing aid coverage only applies to children up to the age of 18 and covers one hearing aid per each hearing impaired ear every 36 months.

In keeping with the newly adopted federal habilitation definition, MSHA requests that MIA change their hearing aid coverage to no longer be limited by age. In the 2016 Notice of Benefit and Payment Parameters final rule, HHS clarified that limiting hearing aids by age is a potentially discriminatory benefit design. We applaud the state of Maryland for not implementing visit limits for medically necessary habilitation services to children under the age of 19 and urge MIA to maintain this requirement. MSHA further recommends that MIA consider allowing visit limits of habilitation services for members aged 19 and above be in parity with coverage and visit limits for children under the age of 19. We recognize that habilitation services for members aged 19 and above are in parity with rehabilitation coverage, but we do not believe that coverage should be arbitrarily reduced because the patient turns 19. The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatment from a range of providers. Services are often considered medically necessary as long as:

- Separate and distinct goals are documented in the treatment plans of physicians, nurses and therapists providing concurrent services;
- The specific services are non-overlapping; and
- Each discipline is providing some service that is unique to the expertise of that discipline and would not be reasonably expected to be provided by other disciplines

MSHA would like to mention that HHS clarified in the most recent regulation that state benefit mandates enacted to define rehabilitative services are part of the essential health benefit—states ***do not*** defray the cost. This clarification allows states to address coverage gaps in their state. For example, Maryland could expand coverage for hearing aids beyond the age of 18 and provide unlimited medically necessary coverage for habilitation services beyond the age of 19 through a state mandate. The enhanced benefits to existing coverage would then become a part of the essential health benefit as a state mandated benefit and the selected benchmark plan would be required to cover these services.

Sincerely,

H. Angela Mezzomo PhD, CCC-SLP
2015 MSHA President

